FOR OHF USE

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040931

Facility Name: COUNTRYSIDE CARE CENTRE

Address: 2330 WEST GALENA BOULEVARD (Number) AURORA (City) 60506 (Zip Code)

County: KANE

Telephone Number: (630) 896-4686 **Fax #** (630) 896-7868

IDPA ID Number: 36-3961908

Date of Initial License for Current Owners: 07/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	131	Skilled (SNF)	131	47,815	1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	76	27,740	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	207	TOTALS	207	75,555	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,353	968	5,900	12,221	8
9	SNF/PED					9
10	ICF	45,866	8,297	2,814	56,977	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	51,219	9,265	8,714	69,198	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.59%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 50 and days of care provided 4,272

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	330,859	31,976	19,774	382,609		382,609	(2,573)	380,036			1
2	Food Purchase		261,065		261,065		261,065	(2,662)	258,403			2
3	Housekeeping	261,175	43,872		305,047		305,047	3,809	308,856			3
4	Laundry	61,103	28,576	7,531	97,210		97,210	(5,712)	91,498			4
5	Heat and Other Utilities			215,063	215,063		215,063		215,063			5
6	Maintenance	45,409	63,411	45,053	153,873		153,873	(3,023)	150,850			6
7	Other (specify):*			44,433	44,433		44,433		44,433			7
8	TOTAL General Services	698,546	428,900	331,854	1,459,300		1,459,300	(10,161)	1,449,139			8
	B. Health Care and Programs											
9	Medical Director			14,250	14,250		14,250		14,250			9
10	Nursing and Medical Records	3,551,514	149,722	197,547	3,898,783		3,898,783	(71,813)	3,826,970			10
10a	Therapy	80,017		369	80,386		80,386		80,386			10a
11	Activities	113,563	4,108	16,034	133,705		133,705	(1,640)	132,065			11
12	Social Services	67,614		9,912	77,526		77,526		77,526			12
13	CNA Training											13
14	Program Transportation			20	20		20		20			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,812,708	153,830	238,132	4,204,670		4,204,670	(73,453)	4,131,217			16
	C. General Administration											
17	Administrative	179,697		795,331	975,028		975,028	(802,922)	172,106			17
18	Directors Fees											18
19	Professional Services			424,323	424,323		424,323	(268,791)	155,532			19
20	Dues, Fees, Subscriptions & Promotions			172,147	172,147		172,147	(108,825)	63,322			20
21	Clerical & General Office Expenses	143,144	57,493	61,827	262,464		262,464	230,056	492,520			21
22	Employee Benefits & Payroll Taxes			902,567	902,567		902,567		902,567			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,985	9,985		9,985	12,238	22,223			24
25	Other Admin. Staff Transportation			5,867	5,867		5,867		5,867			25
26	Insurance-Prop.Liab.Malpractice			225,082	225,082		225,082	32,441	257,523			26
27	Other (specify):*			178,608	178,608		178,608	(178,608)				27
28	TOTAL General Administration	322,841	57,493	2,775,737	3,156,071		3,156,071	(1,084,411)	2,071,660			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,834,095	640,223	3,345,723	8,820,041		8,820,041	(1,168,025)	7,652,016			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: COUNTRYSIDE CARE CENTRE **#0040931** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	12,030	
	REPAIRS & MAINTENANCE		7,744	
			0	19,774
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		7,531	
			0	7,531
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		65,055	
	ELECTRICITY		82,438	
	WATER		67,570	
	CABLE TV - LOBBY		0	
			0	215,063
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		14,250	
	PAINTING & DECORATING		4,033	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		15,607	
	ELEVATOR MAINTENANCE & REPAIR		4,884	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,050	
	FIRE SERVICE		2,229	
			0	
			0	
			0	45,053
7	**OTHER**			
	SCAVENGER		40,239	
	SECURITY SERVICE		4,194	44,433
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	14,250	14,250

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	68,298	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,456	
	PHARMACY CONSULTANT	XVIII B 39-2	2,400	
	UTILIZATION REVIEW FEES	XVIII B 46-2	6,000	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	119,393	
			0	
			0	197,547
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		153	
	SPEECH THERAPY SERVICES		33	
	OCCUPATIONAL THERAPY SERVICES		183	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	369
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		13,298	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,736	
			0	16,034
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	9,000	
	SOCIAL WORKER	XVIII B 45-2	912	
			0	9,912
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number COUNTRYSIDE CARE CENTRE #0040931 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		20	20
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	795,331	795,331
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	36,598	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	387,725	
			0	424,323
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	73,022	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	15,753	
	EMPLOYEE WANT ADS	XIX F	45,574	
	CONTRIBUTIONS	VI 20 XIX F	295	
	DUES & SUBSCRIPTIONS	XIX F	9,649	
	LICENSES & PERMITS	XIX F	4,361	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	16,462	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	5,081	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,950	172,147
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		4,643	
	EQUIPMENT REPAIR & MAINTENANCE		13,788	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	45	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		41,049	
	MESSENGER SERVICE		2,302	
			0	61,827

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	365,334	
	UNEMPLOYMENT COMPENSATION	XIX D	80,879	
	WORKERS COMPENSATION INSURANCI	XIX D	132,367	
	HOSPITALIZATION INSURANCE	XIX D	297,991	
	EMPLOYEE BENEFITS - OTHER	XIX D	16,626	
	EMPLOYEE PHYSICAL EXAMS	XIX D	2,120	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	7,250	
	CHICAGO HEAD TAX	XIX D	0	902,567
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	9,534	
	TRAVEL	XIX G	451	
			0	
			0	9,985
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		5,867	5,867
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		225,082	225,082
27	**OTHER**			
	BAD DEBTS	VI 24	178,608	
				178,608

GRAND TOTAL COLUMN 3 OTHER 3,345,723

COUNTRYSIDE CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	261,065	PATIENT MEALS	207594
LESS SALES TAX	(2,662)	ADD EMPLOYEE MEALS	0
NET FOOD	258,403	TOTAL MEALS/YEAR	207594
TOTAL PATIENT CENSUS	69,198	NET FOOD	258403
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	207594
TOTAL PATIENT MEALS	207594	COST PER MEAL	1.24
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number COUNTRYSIDE CARE CENTRE #0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			102,790	102,790		102,790	186,261	289,051			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			166,527	166,527		166,527	278,789	445,316			32
33	Real Estate Taxes			136,609	136,609		136,609		136,609			33
34	Rent-Facility & Grounds			762,850	762,850		762,850	(717,991)	44,859			34
35	Rent-Equipment & Vehicles			29,263	29,263		29,263	11,289	40,552			35
36	Other (specify):* STORAGE											36
37	**TOTAL Ownership**			1,198,039	1,198,039		1,198,039	(241,652)	956,387			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		169,218	558,377	727,595		727,595		727,595			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,333	113,333		113,333		113,333			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		169,218	671,710	840,928		840,928		840,928			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,834,095	809,441	5,215,472	10,859,008		10,859,008	(1,409,677)	9,449,331			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(14,725)	30		9
10	Interest and Other Investment Income	(131)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,662)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(45)	21		18
19	Entertainment	(73,022)	20		19
20	Contributions	(5,376)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(5,011)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(178,608)	27		24
25	Fund Raising, Advertising and Promotional	(15,753)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(16,462)	20		28
29	Other-Attach Schedule	(9,092)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (320,887)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,088,790)	PG 6-6E	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,088,790)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,409,677)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

COUNTRYSIDE CARE CENTRE

ID# 0040931

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ (2,965)	6	1
2	VACATION ACCRUAL	(2,573)	1	2
3	VACATION ACCRUAL	3,809	3	3
4	VACATION ACCRUAL	(5,712)	4	4
5	VACATION ACCRUAL	(58)	6	5
6	VACATION ACCRUAL	4,827	10	6
7	VACATION ACCRUAL	(1,640)	11	7
8	VACATION ACCRUAL	(9,361)	17	8
9	VACATION ACCRUAL	4,581	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(9,092)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(2,573)	0	0	0	0	0	0	0	0	0	0	(2,573)	1
2	Food Purchase	(2,662)	0	0	0	0	0	0	0	0	0	0	(2,662)	2
3	Housekeeping	3,809	0	0	0	0	0	0	0	0	0	0	3,809	3
4	Laundry	(5,712)	0	0	0	0	0	0	0	0	0	0	(5,712)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(3,023)	0	0	0	0	0	0	0	0	0	0	(3,023)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,161)	0	0	0	0	0	0	0	0	0	0	(10,161)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	4,827	0	0	(76,640)	0	0	0	0	0	0	0	(71,813)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,640)	0	0	0	0	0	0	0	0	0	0	(1,640)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	3,187	0	0	(76,640)	0	0	0	0	0	0	0	(73,453)	16
	C. General Administration													
17	Administrative	(9,361)	0	(594,728)	0	0	(198,833)	0	0	0	0	0	(802,922)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,011)	8,906	(83,525)	1,666	(190,827)	0	0	0	0	0	0	(268,791)	19
20	Fees, Subscriptions & Promotions	(110,613)	0	993	332	463	0	0	0	0	0	0	(108,825)	20
21	Clerical & General Office Expenses	4,536	0	34,823	2,472	188,225	0	0	0	0	0	0	230,056	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,455	5,747	3,036	0	0	0	0	0	0	12,238	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	25,799	1,960	2,339	2,343	0	0	0	0	0	0	32,441	26
27	Other (specify):*	(178,608)	0	0	0	0	0	0	0	0	0	0	(178,608)	27
28	**TOTAL General Administration**	(299,057)	34,705	(637,022)	12,556	3,240	(198,833)	0	0	0	0	0	(1,084,411)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(306,031)	34,705	(637,022)	(64,084)	3,240	(198,833)	0	0	0	0	0	(1,168,025)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(14,725)	200,986	0	0	0	0	0	0	0	0	0	186,261	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(131)	278,920	0	0	0	0	0	0	0	0	0	278,789	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(762,850)	0	1,390	43,469	0	0	0	0	0	0	(717,991)	34
35	Rent-Equipment & Vehicles	0	0	3,588	5,094	2,607	0	0	0	0	0	0	11,289	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(14,856)	(282,944)	3,588	6,484	46,076	0	0	0	0	0	0	(241,652)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(320,887)	(248,239)	(633,434)	(57,600)	49,316	(198,833)	0	0	0	0	0	(1,409,677)	45

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED		COUNTRYSIDE HEALTH CARE CENTRE		
		NURSING HOMES			MORTON GROVE, IL	REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED		
				ENTITIES		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 762,850	COUNTRYSIDE HEALTH CARE CENTRE		$	$ (762,850)	1
2	V	19	ACCOUNTING FEES		" "		7,800	7,800	2
3	V	26	MORTGAGE INSURANCE		" "		25,799	25,799	3
4	V	30	DEPRECIATION - BLDG/IMP		" "		200,530	200,530	4
5	V	30	DEPRECIATION - EQPT/FURN		" "		456	456	5
6	V	32	AMORTIZATION - MTG COST		" "		1,283	1,283	6
7	V	32	INTEREST - MORTGAGE		" "		256,919	256,919	7
8	V	32	INTEREST - OTHER		" "		20,718	20,718	8
9	V	19	DATA PROCESSING		" "		204	204	9
10	V	19	PROFESSIONAL FEES		" "		902	902	10
11	V								11
12	V								12
13	V								13
14	Total			$ 762,850			$ 514,611	$ * (248,239)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$ 99,190	WITTINGHAM MANAGEMENT ASSOCIATES		$ 15,665	$ (83,525)	15
16	V	20	DUES & SUBSCRIPTIONS		" "		993	993	16
17	V	21	CLERICAL		" "		34,823	34,823	17
18	V	24	TRAVEL		" "		3,455	3,455	18
19	V	26	INSURANCE		" "		1,960	1,960	19
20	V	35	RENT - EQPT & VEHICLE		" "		3,588	3,588	20
21	V	17	ADMINISTRATIVE	596,498	" "		1,770	(594,728)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 695,688			$ 62,254	$ * (633,434)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$ 119,393	CARLYLE NURSING ASSOCIATES, LLC		$ 42,753	$ (76,640)	15
16	V	19	PROFESSIONAL FEES		" "		1,666	1,666	16
17	V	20	DUES & SUBSCRIPTIONS		" "		332	332	17
18	V	21	CLERICAL		" "		2,472	2,472	18
19	V	24	TRAVEL		" "		5,747	5,747	19
20	V	26	INSURANCE		" "		2,339	2,339	20
21	V	30	DEPRECIATION		" "				21
22	V	34	RENT		" "		1,390	1,390	22
23	V	35	RENT - EQPT & VEHICLE		" "		5,094	5,094	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 119,393			$ 61,793	$ * (57,600)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$ 196,416	THE KENSINGTON GROUP, LLC		$ 5,589	$ (190,827)	15
16	V	20	DUES & SUBSCRIPTIONS		" "		463	463	16
17	V	21	CLERICAL		" "		188,225	188,225	17
18	V	24	TRAVEL		" "		3,036	3,036	18
19	V	26	INSURANCE		" "		2,343	2,343	19
20	V	30	DEPRECIATION		" "				20
21	V	34	RENT		" "		43,469	43,469	21
22	V	35	RENT - EQPT & VEHICLES		" "		2,607	2,607	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 196,416			$ 245,732	$ * 49,316	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$ 198,833	CHESTERFIELD, LLC		$	$ (198,833)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 198,833			$ 0	$ * (198,833)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: WITTINGHAM MANAGEMENT ASSOC. LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	328,617	6	$ 74,383	$	69,198	$ 15,665	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	328,617	6	4,713		69,198	993	2
3	21	CLERICAL	PATIENT DAYS	328,617	6	165,350	139,276	69,198	34,823	3
4	24	TRAVEL	PATIENT DAYS	328,617	6	16,404		69,198	3,455	4
5	26	INSURANCE	PATIENT DAYS	328,617	6	9,305		69,198	1,960	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	328,617	6	17,037		69,198	3,588	6
7	17	ADMINISTRATIVE	PATIENT DAYS	328,617	6	8,406	8,406	69,198	1,770	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 295,598	$ 147,682		$ 62,254	25

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARLYLE NURSING ASSOC. LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT HOURS	1	1	$ 42,753	$ 42,753	1	$ 42,753	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	483,650	9	11,646		69,198	1,666	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	483,650	9	2,323		69,198	332	3
4	21	CLERICAL	PATIENT DAYS	483,650	9	17,276		69,198	2,472	4
5	24	TRAVEL	PATIENT DAYS	483,650	9	40,167		69,198	5,747	5
6	26	INSURANCE	PATIENT DAYS	483,650	9	16,351		69,198	2,339	6
7	30	DEPRECIATION	PATIENT DAYS	483,650	9					7
8	34	RENT	PATIENT DAYS	483,650	9	9,715		69,198	1,390	8
9	35	RENT - EQPT & VEHICLES	PATIENT DAYS	483,650	9	35,603		69,198	5,094	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 175,834	$ 42,753		$ 61,793	25

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: THE KENSINGTON GROUP, LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	483,650	9	$ 39,055	$	69,198	$ 5,589	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	483,650	9	3,234		69,198	463	2
3	21	CLERICAL	PATIENT DAYS	483,650	9	1,315,340	1,150,879	69,198	188,225	3
4	24	TRAVEL	PATIENT DAYS	483,650	9	21,213		69,198	3,036	4
5	26	INSURANCE	PATIENT DAYS	483,650	9	16,374		69,198	2,343	5
6	30	DEPRECIATION	PATIENT DAYS	483,650	9			69,198		6
7	34	RENT	PATIENT DAYS	483,650	9	303,769		69,198	43,469	7
8	35	RENT - EQPT & VEHICLES	PATIENT DAYS	483,650	9	18,215		69,198	2,607	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,717,200	$ 1,150,879		$ 245,732	25

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY - COUNTRYSIDE HEALTHCARE CENTRE						$	$			$	1
2	GMAC		X	MORTGAGE	$60,450.43	12/03	4,826,200	4,732,299	12/38	0.0540	256,919	2
3	GMAC		X	LOAN COST	35 YR AMORT	12/03	52,135	42,268			1,283	3
4												4
5												5
	Working Capital											
6	LOAN - PARTNERS	X		WORKING CAPITAL	VARIES	06/99	108,600	186,410	DEMAND	VARIES	14,713	6
7	RELATED PARTIES	X		WORKING CAPITAL	VARIES	12/98	498,989	2,760,294	DEMAND	VARIES	168,298	7
8	LETTER OF CREDIT		X								4,234	8
9	TOTAL Facility Related				$60,450.43		$ 5,485,924	$ 7,721,271			$ 445,447	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,485,924	$ 7,721,271			$ 445,447	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	125,052	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	130,117	2
3. Under or (over) accrual (line 2 minus line 1).	$	5,065	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	131,544	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	136,609	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	94,448	8
2001	97,597	9
2002	105,650	10
2003	123,696	11
2004	130,117	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COUNTRYSIDE CARE CENTRE COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0040931

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-19-176-009	NURSING HOME	$ 130,117.18	$ 130,117.18
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 130,117.18	$ 130,117.18

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,536 B. General Construction Type: Exterior BRICK Frame STEEL CONST. Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	130,679	1981	$ 98,000	1
2	754 BASIS ADJ.		1982	16,345	2
3	TOTALS	130,679		$ 114,345	3

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	207		1981		$ 2,111,156	$	30	$ 70,372	$ 70,372	$ 1,710,894	4
5	754 BASIS ADJ.			1992	403,542	12,811	31.5	12,811		172,949	5
6											6
7											7
8											8
	Improvement Type**										
9	**********RELATED PARTY - COUNTRYSIDE HEALTH CARE CENTRE*****										9
10	BUILDING IMPROVEMENTS			1982	40,076		15			40,076	10
11	VARIOUS IMPROVEMENTS			1983	26,282		15			26,282	11
12	VINYL TILING			1984	76,250		20			76,250	12
13	ROOF REPAIR			1985	6,644		20	170	170	6,644	13
14	VARIOUS IMPROVEMENTS			1986	1,609	26	15		(26)	1,609	14
15	VARIOUS IMPROVEMENTS			1987	36,433	1,157	20	1,822	665	33,707	15
16	BLACK TOP PAVING			1988	1,594		15			1,594	16
17	HOT WATER PIPING			1988	5,837	185	31.5	185		3,184	17
18	ROOFING IMPROVEMENTS			1989	51,879	1,647	31.5	1,647		27,519	18
19	SHOWER STALLS			1990	7,000	222	31.5	222		3,441	19
20	PAVING			1990	7,930	260	15	260		7,930	20
21	VARIOUS IMPROVEMENTS			1991	24,486	777	31.5	777		17,309	21
22	VARIOUS IMPROVEMENTS			1992	43,773	1,390	31.5	1,390		18,629	22
23	VARIOUS IMPROVEMENTS			1993	13,286	421	31.5	421		5,412	23
24	VARIOUS IMPROVEMENTS			1993	40,598	1,041	39	1,041		12,794	24
25	VARIOUS IMPROVEMENTS			1994	214,320	5,494	39	5,494		61,398	25
26	VARIOUS IMPROVEMENTS			1994	62,476	4,167	15	4,167		47,917	26
27	KITCHEN REMODEL/SIGNS			1995	32,836	842	39	842		9,194	27
28	ELECTRICAL & LIGHTING			1995	31,634	811	39	811		7,599	28
29	ROOFING/DOORS/DUCTWORK			1995	15,211	390	39	390		3,670	29
30	ROOF REPAIRS/FIRE DAMPERS			1996	4,300	110	39	110		1,087	30
31	BLACK TOP PAVING			1996	3,400	87	39	87		794	31
32	DUCTWORK			1996	8,584	220	39	220		1,989	32
33	REMOVE & REPLACE HVAC ROOF UNITS			1998	28,363	727	39	727		5,301	33
34	ROOF REPAIRS - PATCHING			1998	6,500	167	39	167		1,315	34
35	STAINLESS DUCTWORK -KITCHEN EXHAUST			1998	3,987	102	39	102		812	35
36	BOILER			1998	6,556	168	39	168		1,281	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WALLCOVERING, CARPETING,ARCHITECT WORK	1999	$ 58,243	$ 2,118	27.5	$ 2,118	$	$ 14,738	37
38	WALLCOVERING, ALARMS/ELECTRIC WORKS	1999	27,515	1,000	27.5	1,000		6,876	38
39	REMODEL KITCHEN/WALLCOVERINGS/DRYWALL	1999	11,104	404	27.5	404		2,744	39
40	DINING RMS/WAHSROOM - REMODEL/NEW ROOF	1999	165,984	6,035	27.5	6,035		40,486	40
41	LANDSCAPING/SECURITY PROJECT	1999	38,968	1,417	27.5	1,417		9,388	41
42	CONCRETE PATIO/DRAINAGE/DUCTWORK	1999	26,186	952	27.5	952		6,228	42
43	FLOOR TILES/WALLCOVERING/WALL REPAIRS	1999	127,185	4,624	27.5	4,624		29,864	43
44	IRRIGATION SYSTEMS/BTY STATIONS	1999	26,058	947	27.5	947		6,037	44
45	NEW ADDITION/EXHAUST FANS/INTERIOR WORK	1999	843,269	30,661	27.5	30,661		190,358	45
46	REMODEL - OFFICES/BATHROOMS/DINING	2000	72,465	2,635	27.5	2,635		15,700	46
47	FIRE DAMPERS AND FLOOR GRILLES	2000	5,226	190	27.5	190		1,132	47
48	DOORS/LAUNDRY RM/CORRIDOR - REMODEL	2000	64,257	2,336	27.5	2,336		13,141	48
49	ELEVATOR OPERATION PANEL	2000	4,490	163	27.5	163		917	49
50	LINT COLLECTOR/REMODELING PLANS	2000	7,595	276	27.5	276		1,507	50
51	SPRINKLER SYSTEMS	2000	8,550	311	27.5	311		1,698	51
52	ELEVATOR WANDERGUARD SYSTEM	2000	5,282	192	27.5	192		1,032	52
53	KITCHEN REMODELING/CARPETING	2000	82,957	3,016	27.5	3,016		16,212	53
54	HOT WATER REC. - MIXING VALVE & CIRCUIT SETTERS	2000	8,604	313	27.5	313		1,656	54
55	FRESH AIR INTAKES/ROOF STANDS	2000	23,244	845	27.5	845		4,472	55
56	FIRE ALARM/DOORS	2000	6,184	225	27.5	225		1,191	56
57	PARKING LOT EXPANSION	2000	35,624	1,295	27.5	1,295		6,853	57
58	GENERATORS	2000	92,626	3,368	27.5	3,368		17,542	58
59	LANDSCAPING/SECURITY PROJECT	2000	12,625	842	15	842		4,630	59
60	RESIDENT ROOM REMODELING & FURNISHING	2000	67,311	2,447	27.5	2,447		12,745	60
61	PATIENT WANDERING SYSTEM	2000	14,541	529	27.5	529		2,755	61
62	STIR FREE LINT FILTER	2000	1,399	51	27.5	51		266	62
63	NEW ROOF	2000	20,995	763	27.5	763		3,911	63
64	RESIDENT ROOM REMODELING & FURNISHING	2000	103,610	3,767	27.5	3,767		19,306	64
65	ROOF REPAIRS	2000	3,300	120	27.5	120		615	65
66	ROOF REPAIR & METACAULK FIRE STRIP	2000	11,211	408	27.5	408		2,057	66
67	ROOF TOP HVAC UNIT	2000	7,350	267	27.5	267		1,346	67
68	ELECTRICAL WORK/RESIDENT RMS REMODEL	2000	109,053	3,965	27.5	3,965		19,991	68
69	REMOVE/INSTL FLOOR & DRYWALL KITCHEN & LNDRY	2001	16,675	606	27.5	606		2,955	69
70	TOTAL (lines 4 thru 69)		$ 5,426,228	$ 110,310		$ 181,491	$ 71,181	$ 2,768,929	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,426,228	$ 110,310		$ 181,491	$ 71,181	$ 2,768,929	1
2	METAL SUPPORTS ON AIR RETURNS TO ROOF	2001	3,300	120	27.5	120		585	2
3	INSTALL HYDRAULIC PUMPING UNIT-KITCHEN ELEVATO	2001	7,495	273	27.5	273		1,308	3
4	REPLACE WATER CLOSETS 7 FLUSH VALVES-KITCHEN	2001	7,737	281	27.5	281		1,300	4
5	NEW HALL DOOR LOCKING ASSEMBLIES-ALL FLOORS	2001	2,885	105	27.5	105		477	5
6	PUMP FOR IRRIGATION SYSTEM	2001	1,825	66	27.5	66		300	6
7	INSTALL 4" FLOOR CLEANOUT ON SANITARY WASTE LIN	2001	6,783	247	27.5	247		998	7
8	INSTALLED 4 ELECTRIC HEATERS - CUSTOM	2002	5,297	193	27.5	193		764	8
9	ELECTRICAL WIRING FOR DISHWASHER & BOOSTER HT	2002	14,988	545	27.5	545		2,157	9
10	SHWR RM REPAIRS, REMOVE OLD & FURNISH/INSTL.NEV	2002	26,388	959	27.5	959		3,797	10
11	REPLACED GEAR BOX ON INNER SLIDING ELEC. DOOR	2002	2,289	83	27.5	83		273	11
12	REMOVED & INSTALLED 2 HEAT EXCHANGERS	2002	2,040	74	27.5	74		237	12
13	REMOVE & INSTALL ROOF TOP HEAT EXCHANGER	2002	1,523	55	27.5	55		167	13
14	PARKING LOT - REMOVE & REPLACE ASPHALT	2002	87,477	5,835	15	5,835		20,630	14
15	F&I ONE INFRA RED DOOR SCREEN ON SERV. ELEVATOR	2003	1,350	49	27.5	49		129	15
16	INSTALL 3/4" HP SUMP PUMP & 1-1/2 CK VALVE	2003	1,320	48	27.5	48		122	16
17	INSTALL WATER SOFTENER	2003	2,400	87	27.5	87		214	17
18	2-452E SINGLE SOFTENER; 450,000 GRAINS	2003	9,598	349	27.5	349		858	18
19	SUPPLY & INSTALL WIRING FOR NEW 208-VOLT FREEZEI	2003	1,651	60	27.5	60		138	19
20	REMOVE & INSTALL AZT FLOOR, RMS 602,611,614,705,702	2003	3,666	133	27.5	133		272	20
21	INSTALLATION OF 75 LINEAR FOOT EXTENSION DRAIN	2004	25,374	923	27.5	923		1,423	21
22	REPAIRS TO SPRINKLER DUE TO NEW CONSTRUCTION	2004	2,264	82	27.5	82		113	22
23	OUTSIDE INJECTOR POWER PUMP	2004	3,646	133	27.5	133		183	23
24	PLANTING OF ALPINE TREES AS PART OF DRAINAGE PRO	2004	3,751	250	15	250		375	24
25	NEW STORAGE GARAGE BUILDING	2004	81,144	2,950	27.5	2,950		3,811	25
26	COMPRESSOR	2004	2,100	76	27.5	76		98	26
27	NEW FIRE DOORS	2004	1,377	50	27.5	50		65	27
28	NEW AZT FLOOR TILES FOR RMS 806,812,303,512,313,314	2004	5,590	203	27.5	203		245	28
29	IRON RAILS FOR STAIR WELLS	2004	4,200	153	27.5	153		185	29
30	REPLACE FLOOR TILES & WALL TILES IN RMS 502,505,								30
31	506,511,512,514,805,&807	2005	5,600	127	27.5	127		127	31
32	REMOVE OLD DUCT, FABRICATE & INSTALL NEW MAIN								32
33	TRUCK LINE, INSTALL NEW DIFFUSERS - 1ST FLR WEST V	2005	28,000	636	27.5	636		636	33
34	TOTAL (lines 1 thru 33)		$ 5,779,286	$ 125,455		$ 196,636	$ 71,181	$ 2,810,916	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,779,286	$ 125,455		$ 196,636	$ 71,181	$ 2,810,916	1
2	REPLACE 5 TON CONDENSING UNIT FOR KITCHEN	2005	4,441	101	27.5	101		101	2
3	WALLPAPER IN 1ST FLR REST ROOMS/SHOWER RMS	2005	45,550	897	27.5	897		897	3
4	COMPLETE NEW ROOF ON 3 SECTIONS	2005	105,515	2,079	27.5	2,079		2,079	4
5	REMOVE & REPLACE A.O. SMITH WATER HEATER	2005	12,468	246	27.5	246		246	5
6	REPLACE SIDE WALKS	2005	4,000	67	27.5	67		67	6
7	INSTALLED FRAMES & ROOFED IN FRESH AIR TAKES	2005	5,530	59	27.5	59		59	7
8	INSTALL 2 TON MITSUBISHI UNIT FOR KITCHEN	2005	10,828	115	27.5	115		115	8
9	INSTALL DINING ROOM DOORS & FRAMES	2005	2,231	17	27.5	17		17	9
10	REMOVE & INSTALL VINYL FLOORING	2005	3,900	18	27.5	18		18	10
11	INSTALL 667 SQ YARDS OF NYLON CARPET	2005	38,420	175	27.5	175		175	11
12	A/C SPLIT SYSTEM FOR STORAGE RM, PAINTING & DRY-								12
13	WALL WORK, FIRE ALARM, SMOKE DETECTORS,								13
14	ELECTRICAL WORK IN OXYGEN STORAGE RM.	2005	16,511	75	27.5	75		75	14
15	REPLACE ROOF TOP UNIT - 1ST FLOOR DINING RM.	2005	9,842	45	27.5	45		45	15
16									16
17			SL ADJ.	71,181			(71,181)		17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,038,522	$ 200,530		$ 200,530	$	$ 2,814,810	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 969,324	$ 82,850	$ 83,080	$ 230	3-15 YRS	$ 448,094	71
72	Current Year Purchases	99,702	19,940	4,985	(14,955)	3-15 YRS	4,985	72
73	Fully Depreciated Assets	40,992					40,992	73
74	RELATED PARTIES		456	456				74
75	TOTALS	$ 1,110,018	$ 103,246	$ 88,521	$ (14,725)		$ 494,071	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,262,885	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 303,776	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 289,051	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (14,725)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,308,881	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 25,721 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	99 DODGE RAM PR 2W	$ 295.13	$ 3,542	17
18					18
19					19
20					20
21	TOTAL		$ 295.13	$ 3,542	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 226,270	$		$ 226,270	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			68,210			68,210	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			263,897			263,897	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				128,551		128,551	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB, X-RAY, RENTALS, I.V. TPY & Other (specify): MEDICAL SUPPLIES	39-2					40,667		40,667	13
14	TOTAL			$		$ 558,377	$ 169,218		$ 727,595	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 93,449	$ 247,596	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 247,599)	1,560,550	1,560,550	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,883	1,883	5
6	Prepaid Insurance	66,054	170,798	6
7	Other Prepaid Expenses	23,360	27,739	7
8	Accounts Receivable (owners or related parties)	880	3,085	8
9	Other(specify): ESCROW DEPOSITS		529,382	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,746,176	$ 2,541,033	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		98,000	13
14	Buildings, at Historical Cost		2,111,156	14
15	Leasehold Improvements, at Historical Cost		3,523,820	15
16	Equipment, at Historical Cost	1,110,018	1,110,018	16
17	Accumulated Depreciation (book methods)	(939,032)	(3,741,376)	17
18	Deferred Charges		42,268	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 170,986	$ 3,143,886	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,917,162	$ 5,684,919	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 455,232	$ 455,232	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	142,545	142,545	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	191,254	191,254	30
31	Accrued Taxes Payable (excluding real estate taxes)	33,145	33,145	31
32	Accrued Real Estate Taxes(Sch.IX-B)		131,544	32
33	Accrued Interest Payable	72	21,367	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	56,348	56,348	36
37	DUE TO DPA	20,205	20,205	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 898,801	$ 1,051,640	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,612,957	2,946,704	39
40	Mortgage Payable		4,732,299	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO LESSOR/PRIOR OWNER	760,265		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,373,222	$ 7,679,003	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,272,023	$ 8,730,643	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,354,861)	$ (3,045,724)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,917,162	$ 5,684,919	48

***(See instructions.)**

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,160,669)	1
2	Restatements (describe):		2
3			3
4	ROUNDING ADJ	5	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,160,664)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(944,197)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(250,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,194,197)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,354,861)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,912,252	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,912,252	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	155	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,273	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,428	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	131	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 131	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,914,811	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,459,300	31
32	Health Care	4,204,670	32
33	General Administration	3,156,071	33
	B. Capital Expense		
34	Ownership	1,198,039	34
	C. Ancillary Expense		
35	Special Cost Centers	727,595	35
36	Provider Participation Fee	113,333	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,859,008	40
41	**Income before Income Taxes (line 30 minus line 40)****	(944,197)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (944,197)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,884	2,392	$ 88,758	$ 37.11	1
2	Assistant Director of Nursing	3,544	4,135	123,135	29.78	2
3	Registered Nurses	31,059	34,380	982,119	28.57	3
4	Licensed Practical Nurses	21,162	22,551	594,378	26.36	4
5	CNAs & Orderlies	110,550	117,882	1,647,891	13.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,056	5,445	80,017	14.70	8
9	Activity Director	1,908	2,431	37,644	15.48	9
10	Activity Assistants	7,693	8,218	75,919	9.24	10
11	Social Service Workers	3,938	4,203	67,614	16.09	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	10,877	12,161	160,396	13.19	14
15	Cook Helpers/Assistants	19,486	20,899	170,463	8.16	15
16	Dishwashers					16
17	Maintenance Workers	2,010	2,251	45,409	20.17	17
18	Housekeepers	25,670	27,833	261,175	9.38	18
19	Laundry	5,726	6,269	61,103	9.75	19
20	Administrator	1,941	2,178	122,998	56.47	20
21	Assistant Administrator	1,944	2,692	56,699	21.06	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,126	8,912	143,144	16.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,302	5,742	115,233	20.07	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	267,876	290,574	$ 4,834,095 *	$ 16.64	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	240	$ 12,030	1-3	35
36	Medical Director	124	14,250	9-3	36
37	Medical Records Consultant	32	1,456	10-3	37
38	Nurse Consultant	834	119,393	10-3	38
39	Pharmacist Consultant	96	2,400	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	48	2,736	11-3	44
45	Social Service Consultant	112	9,912	12-3	45
46	Other(specify) UTILIZATION REV.	36		10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,522	$ 162,177		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,239	$ 58,507	10-3	50
51	Licensed Practical Nurses	234	9,791	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)	1,473	$ 68,298		53

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KIM KOHLS	ADMIN		$ 122,998
VIVIAN MCCAIN	ASST ADMIN		40,625
KATIE MCGOVERN	ASST ADMIN		16,074
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 179,697

B. Administrative - Other

Description	Amount
WITTINGHAM MANAGEMENT ASSOC. LLC	$ 596,498
CHESTERFIELD, LLC	198,833
TOTAL (agree to Schedule V, line 17, col. 3)	$ 795,331
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		424,323
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 424,323

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 132,367
Unemployment Compensation Insurance		80,879
FICA Taxes		365,334
Employee Health Insurance		297,991
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		16,626
EMPLOYEE PHYSICAL EXAMS		2,120
PENSION/PROFIT SHARING PLANS		7,250
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 902,567

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	45,574
Health Care Worker Background Check	1,950
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	105,237
TRUST/FRANCHISE/CONTRIB/ETC	5,376
LICENSES & PERMITS	4,361
DUES & SUBSCRIPTIONS	9,649
MGMT CO ALLOCATION	1,788
TRUST/FRANCHISE/CONTRIB/ETC	(5,376)
Less: Public Relations Expense	(73,022)
Non-allowable advertising	(15,753)
Yellow page advertising	(16,462)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 63,322

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	451
RELATED PARTY	12,238
Seminar Expense	
	9,534
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 22,223

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING	2002	$ 2,374	3	$ 396	$ 791	$ 791	$ 396	$	$	$	$	$
2	PAINT/DECORATING	2005	4,033	3				672	1,344	1,344	673		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 6,407		$ 396	$ 791	$ 791	$ 1,068	$ 1,344	$ 1,344	$ 673	$	$

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILL COUNCIL ON LTC - $11536.80**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **YES** If YES, have these costs
been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **3,501** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **113,333**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees